Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

## Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: LAA-0111M1, Application for SERFF Tr Num: NWPA-127385672 State: Arkansas

Individual Life Insurance REVISION

TOI: L08 Life - Other SERFF Status: Closed-Approved-State Tr Num: 49632

Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: LAA-0111M1; LAA- State Status: Approved-Closed

0112M1; LAA-0113M1,

APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

Filing Type: Form Reviewer(s): Linda Bird

Authors: Amy Burchette, Sandra Disposition Date: 08/31/2011

Davies, Dan Gallion, Cindy Malloy, Carrie Ruhlen, Georgia Sollars, Drema Wallace, Leslie Hernandez

Date Submitted: 08/25/2011 Disposition Status: Approved-

Closed

Implementation Date Requested: 11/04/2011 Implementation Date:

State Filing Description:

## **General Information**

Project Name: LAA-0111M1, Application for Individual Life Insurance Status of Filing in Domicile: Pending

**REVISION** 

Project Number: LAA-0111M1, Application for Individual Life Insurance Date Approved in Domicile:

**REVISION** 

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Overall Rate Impact: Filing Status Changed: 08/31/2011

State Status Changed: 08/31/2011

Deemer Date: Created By: Carrie Ruhlen

Submitted By: Carrie Ruhlen Corresponding Filing Tracking Number: LAA-

0111M1, Application for Individual Life

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

Insurance REVISION

Filing Description:

Re: LAA-0111M1, Application for Individual Life Insurance LAA-0112M1, Application for Individual Life Insurance LAA-0113M1, Application for Individual Life Insurance NAIC #92657

We are writing to inform you of a revision to the applications included in this filing, which were recently approved in your Department on 08-05-2011 (SERFF #NWPA-127334583, State Tracking #49421). You have our assurance these forms have never been used, so we have kept the form number the same.

Due to an objection from another State Insurance Department, we felt it necessary to change the authorization section across the board. Several revisions have been made to the authorization, so we ask that you review the entire section.

No other sections of the application forms were revised.

We sincerely apologize for any inconvenience this change has caused, and appreciate your time in this matter.

We still plan to begin using the approved forms on the latter of November 4, 2011 or upon approval.

Thank you in advance for your attention to this matter. Please call me if you have any questions on this filing.

## **Company and Contact**

### **Filing Contact Information**

Carrie Ruhlen, Compliance Specialist ruhlenc@nationwide.com
One Nationwide Plaza 614-249-8042 [Phone]
1-33-102 614-249-1199 [FAX]

Columbus, OH 43215

**Filing Company Information** 

Nationwide Life and Annuity Insurance CoCode: 92657 State of Domicile: Ohio

Company

One Nationwide Plaza Group Code: 140 Company Type: 1-10-03 Group Name: State ID Number:

Columbus, OH 43215 FEIN Number: 31-1000740

(800) 882-2822 ext. [Phone]

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

-----

## **Filing Fees**

Fee Required? Yes

Fee Amount: \$150.00

Retaliatory? Yes

Fee Explanation: \$50.00 per form.

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Nationwide Life and Annuity Insurance \$150.00 08/25/2011 50957829

Company

SERFF Tracking Number: NWPA-127385672 State: Arkansas

Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49632

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

## **Correspondence Summary**

## **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/31/2011	08/31/2011

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

## **Disposition**

Disposition Date: 08/31/2011

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

Schedule	Schedule Item	Schedule Item Status Public Access
<b>Supporting Document</b>	Flesch Certification	Yes
<b>Supporting Document</b>	Application	Yes
Supporting Document	Statement of Variability	Yes
Form	Application for Individual Life Insurance	Yes
Form	Application for Individual Life Insurance	Yes
Form	Application for Individual Life Insurance	Yes

Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

## Form Schedule

Lead Form Number: LAA-0111M1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAA- 0111M1	Application/Application for Enrollment Individual Life Form Insurance	Initial		48.400	LAA- 0111M1.pdf
	LAA- 0112M1	Application/Application for Enrollment Individual Life Form Insurance	Initial		48.400	LAA- 0112M1.pdf
	LAA- 0113M1	Application/Application for Enrollment Individual Life	Initial		48.400	LAA- 0113M1.pdf

#### NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance [P.O. Box 182835, Columbus, Ohio 43218-2835] PART A - CLIENT INFORMATION Proposed Name (First, MI, Last) SSN / Tax ID # Primary John D. Doe 000 00 - 0000 Address City Insured One Any Street Any City Zip Code County Former Name State Sex Any State 00000 Any County ×M Marital Status Age 35 Date of Birth (mm/dd/yyyy) State of Birth ■ Married □ Single □ Other 02/07/1973 OH E-Mail Address Phone #  $\square$  AM ) 000-0000 JDDOE@YAHOO.COM 000 **⋈** PM Driver's License # / State of Issue Net Worth Annual Income RL000000 OH Occupation **Employer** Citizenship (If other, submit Foreign Supplement.) □ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.? Name of Additional Proposed Relationship to Birth Birth Date Sex Height Weight SSN / Tax ID # Additional Insured(s) State Primary Insured Insured If applicable, complete for either: a) Joint Insured for Joint/Spouse Proposed Additional Insured Information Only Survivorship Life Address \(\superatorname{\text{\text{\$\text{Check box if same as Proposed Primary Insured}}\)}\) Former Name Plan; or b) Term Rider on Zip Code City State County Another Covered E-Mail Address  $\square$  AM Person (i.e., Phone #  $\square$  PM Spouse/Children) Driver's License # / State of Issue Net Worth Annual Income If additional space is required, use Citizenship (If other, submit Foreign Supplement.) Occupation **Employer** Special Instructions ☐ Canada □ U.S. Section. ☐ Other, how long have you lived in the U.S.? SSN / Tax ID # Owner Name (First, MI, Last) Complete ONLY if Address \(\subseteq\) (Check box if same as Proposed Primary Insured) City Owner is not the Proposed Primary State Zip Code County Date of Birth (mm/dd/yyyy) Phone #  $\square$  AM Insured.  $\square$  PM Unless indicated the Type of Owner Relationship to Insured E-Mail Address Proposed Primary ☐ Individual ☐ Employer ☐ Trust Insured (Joint ☐ Rabbi Trust ☐ Other Insureds in the case If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, of Survivorship) will otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The own the policy. If more than two SSN shown above will be used unless otherwise instructed. Owners are Joint Owner (First, MI, Last) SSN / Tax ID # requested, use Special Instructions Address \( \subseteq \text{(Check box if same as Proposed Primary Insured)} \) City Section. Date of Birth (mm/dd/yyyy) State Zip Code County Phone #  $\square$  AM  $\square$  PM Type of Owner Relationship to Insured E-Mail Address ☐ Individual ☐ Employer ☐ Trust TRUST - Submit a ☐ Rabbi Trust ☐ Other copy of first and signature pages of Trust Tax Date of **Exact Name of Trust** Current Trustee(s) Trust document. **ID Number** Trust

4. Contingent Owner	Name (First, MI, Last)				SS	SN / Tax ID #				
Complete this section to name an	Address \( \square\) (Check box if same	as Propos	sed Primary Insul	red)	City					
alternative Owner in the event the Insured survives the Owner.	State Zip Code Cou	nty		Relationsh	nip to Insured	Date of Birth (mm/dd/yyyy)				
5. Primary Beneficiary Designations	When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.  □ Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.									
If Survivorship Life Plan, the Proposed Insureds may not be	For Proposed Primary Insured Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
named as Beneficiary.  If additional space is required, use Special Instructions Section.	Jane S. Doe	100	Wife	10/08/1975	000-00-000	One Any Street One Any State 00000				
Secuon.										
	For Proposed Additional Insu	red								
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
/ Oanthamat	F D									
6. Contingent Beneficiary Designations	For Proposed Primary Insurer Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
If additional space is required, use Special Instructions Section.										
Sconori.	For Proposed Additional Insu	red								
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
7. Taxpayer ID	I certify under penalties of perju	ry that:								
Number	<ul> <li>The number shown on this f</li> <li>I am not subject to backup w</li> <li>I have not been notified dividends, or</li> <li>the Internal Revenue Ser</li> </ul>	orm is my controlling hat I am solution	because ubject to backupotified me that	p withholding as	a result of a	failure to report all interest or ckup withholding, or that I am				
Check box, if applicable	exempt from backup withl  I am a U.S. person (including Check this box if you have because of failure to report The Internal Revenue Service certifications required to avoid	g a U.S. re. e been no t interest o does not	sident alien). htified by the IF or dividends on require your co	ı your tax returi	٦.					



PLAN INFORMATION	_						
8. Life Insurance	☐ Nationwide YourLife® 1	10-yea	ır Term	☐ Nationwide	e Your	Life® Indexed UL	
Plan	☐ Nationwide YourLife® 1			☐ Nationwide			
	☐ Nationwide YourLife® 2		☐ Nationwide YourLife® No-Lapse Guarantee SUL II				
STOP	☐ Nationwide YourLife® 3				Life® Protection VUL		
The Variable Life	☐ Nationwide YourLife® 2					Life® Accumulation VUL	
Fund Supplement	☐ Nationwide YourLife® \					Life® Survivorship VUL	
MUST be completed	☐ Nationwide YourLife® (	Currer	t Assumption UL	☐ Other			
if applying for a	□ Nationwide YourLife® I						
Variable Product.	Base Specified Amount	·	Additional Term Rider/Su	ınnlemental		Total Specified Amount	
The IUL Allocation	Base opeomod / unoun	+	Coverage Amount <i>(checi</i>		_	(including Additional Term Rider/	
Form <b>MUST</b> be			availability)	( plan roi	=	Supplemental Coverage)	
completed if			avallability)			Supplemental Coverage)	
applying for an Index UL Product.	\$ 250,000.00		\$			\$250,000.00	
9. Additional	Death Benefit Option (If	no or	ntion is selected here, Op	tion 1 is electe	ed )		
Options	-					Value, whichever is greater.)	
STOP				umulateu valut	e, ui a	multiple of the Cash/Accumulated	
Complete this section			er is greater.)	d Dromium Aga	ount at	0/* interest or a multiple of the	
if you applied for a						%* interest or a multiple of the	
Variable Universal,						entage up to 12% maximum, ONLY if	
Universal or					Owne.	r is not a business entity, 0% will apply.	
Survivorship Life			surance Qualification Te	st Option			
Plan.	■ Guideline Premium/Ca						
	□ Cash Value Accumulat						
	(If no selection is made he	ere, th	e Guideline Premium/Cash	n Value Corrido	r Test	is elected.)	
10. Optional	Variable or Universal Lif	fe Pla	ns Only <i>(Subject to Plan a</i>	availability.)		_	
Benefits	☐ Spouse Rider		\$	☐ Change o	f Insu	red Rider	
Check Plan for	☐ Children's Term Insura	nce R	lider \$	☐ Other Rid	er(s)_		
Availability.	☐ Long Term Care Rider			☐ Other Rid	er(s)_		
	*Complete Supplemen	nt for L	ong Term Care Rider.	Can select of	nlv o	ne·	
	☐ Accidental Death Bene		ler \$			er Rider\$	
	☐ Adjusted Sales Load F	Rider	%			nly Deductions Rider	
	(in whole percentages	only)	waived for years	Can select of		-	
	☐ Extended Death Benef			☐ Surrender	: Value	e Enhancement Benefit	
			ge (Indicate percentage of			urn of Premium Rider (cannot be	
	specified amou					tended Death Benefit Guarantee Rider)	
	Guarantee Dura	ation	(Indicate number of years)	Ciccica W	<u>L</u> X	Sinded Bedin Benefit Gadrantee Macry	
	Survivorship Variable or	r Surv	ivorship Universal Life P	lans Only (Sui	bject i	to Plan availability.)	
	☐ Four Year Term Rider*	*	\$	☐ Policy Spli	it Optic	on Rider	
			ar Term Insurance has	☐ Other Rid	er(s)		
	been illustrated you s			☐ Other Rid			
	,		y (Subject to Plan availal		(-/_		
					Maiyar	of Premium Death or Disability Benefit	
	☐ Children's Term Insura		\$			3	
						e Part B for the Owner)	
	☐ Accidental Death Bene			Uccupani	ـــــــاال		
	☐ Guaranteed Insurability			neigni			
	☐ Waiver of Premium Dis			weight_	Y		
	☐ Owner's Waiver of Pre						
	(Complete Part B for the						
	Occupation			☐ Other Rid	er(s)_		
	Height			☐ Other Rid	er(s)_		
	Weight						
,	State of Birth						
	Policy will be issued wit	h Aut	omatic Premium Loan Op	otion (APL) foi	· Who	le Life Plans only, if available, unless	
	the box below is checked						
	□ No. do not issue with	API					



FUTURE BILLING AN	ND PREMIUM INFORMATION								
11. Amount Paid	(Be sure to review Temporary Insurance Agreement to verify if the Proposed Insured qualifies to submit premium with								
With	the application.)								
Application	☐ Check/Wire amount with application\$								
Check the	(NOTE: Make al	I checks payable	to <b>NATIONWI</b>	DE.)					
applicable option									
and indicate the premium amount					and complete Sec				
being submitted with	☐ Draft initial pa	yment and future	payments (ind	licate initial p	oremium amount a	nd comp	lete		
the application.	Sections 12 &	13)					\$		
12. Future Billing	Billing Options:				Payment Options				
and Payment	☐ Monthly EFT*		\$		☐ Single Premiu	m	\$		
Options	_	plete Section 13, I			☐ Billing Advanta	age	\$		
Check the	Authorization.	•	,		Account Numb	oer Oer			
applicable billing or	☐ Quarterly		\$		Account Numb  ☐ 1035 Exchang	е	\$		
payment option(s) and indicate the	☐ Semi-Annual.		\$		☐ Other	• • • • • • • • • • • • • • • • • • • •	\$ *		
premium amount.					_ 0		Ψ		
13. Electronic		ectronic Draft O							
Draft				Droft Optio	anc.				
Authorization		y (1 <sup>st</sup> – 28 <sup>th</sup> ):		Draft Option	ng – Use informa	tion on th	o initial promium o	hock	
7.0		Draft Day will be			ing - Ose illioitha ing - (Provide a p			HCCK.	
		cy effective date u	iniess a day		s - (Provide a lei			t <b>h</b> e	
	is requested abo	ive.)			nit/ABA number, Acc				
	13b. If no check	or deposit slip p	provided, indic		he bank informat				
		on Name			Transit/ABA Num				
				_	Type of Account:		heckina □*S	avings	
	*Ry providing my	u financial institut	tion name and		formation, I hereb				
					king/savings acco				
		oit the same such		o my onco	ung/savings acco	ant man	alea above and	tric i mariotar	
14. Payor				er is billed fo	or the premium for	this polic	CV.		
· ·· · · · · · · · · · · · · · · · · ·	Name (First, MI,		. ,		•	,			
	Address				City		State	Zip Code	
	Addiess				City		State	Zip Code	
INSURANCE INFORM	MATION						<u> </u>	· ·	
15. Replacement	☐ Yes <b>区</b> No	a. Do vou have	any other Life	e Insurance	or Annuities eithe	r current	v in force or that	has been sold	
and Other			ty? <i>(If "yes", li</i> i				<i>j</i>		
Policy	☐ Yes <b>区</b> No				ige now applying f	or Life In	surance or Annui	ties with any	
Information		other compar	ny? <i>(If "yes", p</i>	rovide name	of Company, amo	unt appli	ed for and purpos	e of coverage.)	
STOP		'	<i>y</i> ( <i>y</i> ) / (		7 5.	,,	, ,	3 /	
	☐ Yes <b>区</b> No	c. Will any Life	Insurance or	Annuities f	or this or any oth	er comp	any be replaced	discontinued.	
Be sure to answer all questions. If					applied for is issued				
applicable, check					is an IRC Sect 103				
the appropriate box.	☐ Yes <b>区</b> No				age had Life Insura				
					e name of Compa				
		no longer in l		, , ,	,	<i>J</i> ,		3	
			T		T D	4005	Lapsed/	Nationwide	
Insured	Company	Policy Number	Amount Of		To Be	1035	Surrendered/	Term	
	' '	Number	Coverage	Issued	Replaced	Exch	Sold	Conversion	
			\$		☐ Yes ☐ No				
			\$		☐ Yes ☐ No				
	D LITES LINU L								
	\$								
			\$		☐ Yes ☐ No				

FINANCIAL INFORMA	ATION								
16. Financial Questions Explain all "yes" answers in Section	All question Trustee, if of indicate the	Proposed Primary Insured	Proposed Additional Insured	Owner/ Trustee if other than Proposed Insured(s)					
17 Details box below unless			, ,		Yes No	Yes No	Yes No		
instructed otherwise.	policy to a	icy being purchased a life settlement con r other secondary m							
This section needs to be completed by each Proposed	b. Have you sale or as	entered into any ag ssignment of this po	reement, or mad licy to a life settle	e arrangements, for the ment company, trust, ondary market purchaser'	?				
Insured and Owner/ Trustee, if other than Proposed	c. Have you assignme	been involved in arent of this policy to a	ny communication life settlement co	n about the possible sale ompany, trust, limited y market purchaser?					
Insured(s).	d. Have you	ever sold any life ir , trust, limited liabilit	surance policy to						
	e. Will any p	ortion of the current	or future premium	for this policy be finance	d? 🗆 🗷				
	f. Will any Ir the insura	nsured or Policy Ow ance issued on the b	ner receive any p	payment in connection wi	th 🗆 🗷				
17. Explanation of Financial Details	Question Letter	Person	Dates		Details				
If more space is									
needed, an additional blank sheet may be									
attached. Any Proposed Insured(s) or Owner(s) should									
sign and date additional pages.									
PART B - PERSONAL									
18. Tobacco Use All questions are to	Have you us nicotine in a 1. In the last		Propo	osed Primary Insured	•	Proposed Additional Insured  ☐ Yes ☐ No			
be answered by each Proposed Insured.	2. In the last			te last used	If "yes", da	☐ Yes ☐ No ☐ If "yes", date last used. ☐ Yes ☐ No			
STOP		3	If "yes", da	te last used	If "yes", da	If "yes", date last used			
Be sure to answer this section.		heck all forms of pr nicotine products		g Tobacco □ Pipe obacco □ Snuff e Products (gum, patch, e	☐ Chewin☐ Other T	☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Other Tobacco ☐ Snuff ☐ Nicotine Products (gum, patch, etc.)			
19. Physical Measurements	Height	Current Weight	Weight 1 Yea Ago	Reas	on for Weight C	Sain or Loss			
Fill in information for the Proposed Primary Insured.									
20. Personal Physicians	N. CD	151	Proposed Pr Insured		d Additional sured	Any (	Child		
If Child Rider coverage is	Name of Pers Address:	sonal Physician:							
requested, use Special Instructions	Telephone N	umber.							
Section to add Personal Physician	Date last con								
information for each	Reason last of	consulted:							
child.	Treatment given medication property								



21. Personal Details	All questions are to be answered by each Proposed Insured. For each yes answer, indicate the appropriate item(s) and provide details.						Proposed Proposed Primary Additional Insured Insured			
Explain all "yes"							Yes	No	Yes	No
answers in Section 22 Details box below unless instructed otherwise.	applicati	u ever had any applica ion for reinstatement fo ed, rated-up or limited?	r Life or Health	Health Insurance <i>(or any Insurance)</i> declined,	Yes	×				
	or injury?	?		payments for any illness		×				
	flying as automob diving, m jumping,	a pilot, student pilot, or ile, motorcycle, or any	r crew member; type of motor-p g gliding, parach? (If "yes", com	you intend to engage in: organized racing of an nowered vehicle; scuba nuting, sky diving, bungee aplete an Aviation/		×				
	been cor		impaired or into	nded or revoked; or ever oxicated, or in the past 3 g violation?		×				
	convicted	s prescribed by a phys d for sale or possession ug? (If "yes", complete	n of cocaine or	any other narcotic or		×				
	f. Have you	u ever been charged w	ith a violation o	f any criminal law?		×				
	United S	xt 12 months, do you p tates or Canada? <i>(If ")</i> s or Travel.)		reside outside of the Supplement for Foreign		×				
			elong to or intend to join any active or reserve military or naval on? (If "yes", complete Military Status Questionnaire.)							
	i. Have you		s in the past 7 y	ears or do you have any		×				
	j. To the be from can relations and if ca	est of your knowledge, cer or cardiovascular c	do you have a lisease prior to	parent or sibling who died age 60? (If "yes", provide ath, and cause of death,		×				
22. Explanation of Personal	Question Letter	Person	Dates		Det	ails				
Details  If more space is needed, an additional										
blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should										
sign and date additional pages.										

#### **HEALTH INFORMATION** Proposed Proposed 23. Health To the best of your knowledge and belief, has anyone here proposed Any Primary Additional Questions for insurance ever consulted a licensed health care provider for, been Child Insured Insured treated for, taken medication for, or been diagnosed as having: All questions are to Yes No Yes No Yes No be answered by a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-× each Proposed related condition, or received a positive result of an HIV (Human Insured. Immunodeficiency Virus) test? Explain all "yes" Heart disease including heart attack, angina, or other chest pain, × П answers in Section cardiomyopathy, shortness of breath, congestive heart failure, heart 24 Details box murmur, or other disorder of the heart? unless instructed c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, × otherwise. or high triglycerides? Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, × peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism? × e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, П Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder? f. Depression, neurosis, affective disorder, psychosis, or any other mental × or emotional disorder? Asthma, emphysema, chronic bronchitis, tuberculosis, or any other × disease of the lungs or respiratory system? × h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract? Sugar, protein or blood in the urine, kidney stones, sexually transmitted × disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system? Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, × or thyroid? Disorder of the blood including anemia, sickle cell disorders, × thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors? Cancer, or any malignant or benign tumor or cyst, or any chronic × disease of the skin or lymph glands? m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic × back or muscle condition? n. Alcoholism, narcotic addiction, drug use, or hallucinations? × П × o. Any disease or disorder of the eyes, ears, nose or throat? П П To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance: p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.) q. Had any disease, disorder, injury, or operation not already disclosed on П × this application? r. Had any x-rays, electrocardiograms, or other medical tests for reasons × not already disclosed on this application? Been medically advised to have any surgery, hospitalization, treatment × or test that was not completed or results that you have not received? Currently taking any medication other than indicated above to include × prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.) Used alcoholic beverages? (If yes, how much, what kind (beer, wine, × liquor), and how often?)



24. Details of Health History  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.  25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.  PART C - FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.	e numbers							
Description of the space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.  25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Ary person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.  25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud. ARKANSAS and  ARKANSAS and  ARKANSAS and								
Proposed Insured(s) or Owner(s) should sign and date additional pages.  25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C - FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
25. Special Instructions Section  If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sadditional pages.  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
Instructions Section  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
Instructions Section  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
Instructions Section  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.								
Instructions Section  PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES  WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing.	sian and data							
WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing	iyir anu uale							
WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing								
WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing								
WYOMING only:  Any person who submits an application or a claim containing a false or deceptive statement, and does so we defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing								
defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.  ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing								
ARKANSAS and Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing								
RHODE ISLAND   false information in an application for insurance is guilty of a crime and may be subject to fines and cor	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in							
only: prison.	prison.							
COLORADO only:  IMPORTANT NOTICE – IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MI FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAID ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, I INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMAT POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEF POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM IN PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEFORMAT OF REGULATORY AGENCIES.	JDING OR DENIAL OF COMPANY ION TO A RAUD THE ISURANCE PARTMENT							
Pre-Notice of This notice is to inform you that as part of our normal underwriting procedures in connection with an ap insurance:	plication for							
• An investigative consumer report may be made whereby information is obtained through personal inte	rviews with							
The Fair Credit general reputation, personal characteristics and mode of living, except as may be related directly or	o cnaracter, indirectly to							
Reporting Act your sexual orientation, with respect to you, members of your family, and others having an interest in	n or closely							
<ul> <li>You may elect to be interviewed if an investigative consumer report is prepared in connection with this</li> </ul>	application.							
You are entitled to receive a copy of any investigative consumer report by submitting your request in written upon your written request, made within a reasonable time after you receive this notice, additional information.								
the nature and scope of the investigation, if one is made, will be provided. You may send corrections a for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. B Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.	nd requests							
Medical Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance	Company,							
Information Bureau or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a membership organization of life insurance companies, which operates an information exchange on be	ehalf of its							
Disclosure Notice members. If you apply to another Bureau member company for life or health insurance coverage or benefits is submitted to such a company, the Bureau, upon request, will supply such company with the internal content of the interna	a claim for							
its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may h	nave in vour							
file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the	· · · · · · · · · · · · · · · · · · ·							
information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone numb	a correction							
6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nati and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be subn	a correction ne Bureau's er 866-692-							

PART D – AGREEME	<u>INT, AUTHORIZATIO</u>	N AND SIGNATURE								
Agreement	I understand and ag	ree that:								
	• This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application.									
	• The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer of									
	Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or									
	make or change any contract; or waive or change any of the Company's rights or requirements.  • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to									
	the extent set forth in that Agreement.									
	If the full first projection  If the full first projection  If the full first projection is a full first project for the ful	emium is not paid with this application	, then insurance will only take effect when (1) a policy is							
	statements made	nwide and accepted by me; and (2) to on the application, medical examination	ne full first premium is paid; and (3) all the answers and n(s) and amendments are true to the best of my knowledge							
	and belief when (	(1) and (2) have occurred.								
Authorization	I authorize: any lice	ensed physician or medical practitioner	r, any hospital, clinic, any pharmacy or pharmacy benefit							
	managers, and other medically related for	er sources who maintain prescription ( acility: any insurance company: the	drug records and related information, or other medical or Medical Information Bureau; or any other organization,							
	institution, or persor	n, to disclose any information concerning	g me, including, but not limited to, my entire medical/health							
	record to the Medic	al Director of Nationwide Life and Ann	uity Insurance Company or its affiliates, including, but not							
	Insurance and to in	rucai, foi the purpose of underwitting ovestigate claims. By my signature be	n my application in order to determine eligibility for Life low, I acknowledge that any agreements I have made to							
	restrict my protected	I health information do not apply to this '	form; and I instruct any physician; health care professional;							
	hospital; clinic; phar	macy or pharmacy benefit managers; medical/bealth record without restriction	nedical facility, or other health care provider to release and							
	pursuant to this fo	rmedical/flealiff fector without restriction may be redisclosed and no long	on. I understand that any information that is disclosed ger be covered by federal rules governing privacy and							
	confidentiality of hea	alth information. This form, or a copy of	fit, will be valid for a period of not more than two years (24)							
	months) from the da	ate it was signed. I understand that I n quest for revocation to Nationwide Life	ave the right to revoke this form in writing, at any time, by and Annuity Insurance Company, [Attention: Underwriting,							
	P.O. Box 182835, C	Columbus, Ohio 43218-2835].  I underst	and that a revocation is not effective to the extent that any							
	of my providers hav	e relied on this form; or to the extent the	nat Nationwide Life and Annuity Insurance Company has a							
	to sign this form to r	. a claim under an insurance policy of to release my complete records, or, if I rev	contest the policy itself. I further understand that if I refuse oke this authorization before a policy is issued, Nationwide							
	Life and Annuity Ins	Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized								
<b>D</b> 1	representative or I h	ave a right to a copy of this form by sen	ding a request to Nationwide in writing.							
Proposed Insured(s) and		S APPLICATION AND AGREEMENT AN VLEDGE AND BELIEF. TUNDERSTAN	ND DECLARE THAT THE ANSWERS ARE TRUE TO THE							
Owner/Trustee	DEST OF WIT KNOW	VEEDOL AND BELIEF. FONDERSTAN	D'AND AOREE TO ALETTS TERMS.							
Signatures	6	A 011 A 01 I	1.1.00							
STOP	Signed at	Any City, Any State City/State	, onJuly 28,2008 Month/Day Year							
		City/State	Month Day Teal							
All Financial questions in Section		John D. Doe	X							
16 (a through f) are	Full Name o	f Proposed Primary Insured (print)	Signature of Proposed Primary Insured							
required to be			(or parent if Proposed Primary Insured is under age 15)							
answered for both			Χ							
the Proposed	Full Name of	Proposed Additional Insured (print)	Signature of Proposed Additional Insured							
Insured(s) and		. ,	(if to be Insured)							
Owner, if not Proposed	V		V							
Insured(s).	XSign	nature of Applicant/Owner	XSignature of Applicant/Owner							
mourou(5).		than the Proposed Insured(s))	(if other than the Proposed Insured(s))							
PART E - PRODUCEI	· · · · · · · · · · · · · · · · · · ·	man the Proposed meaned(e))	(in curior unan uno ri operiora unoairoa (o))							
Producer's	¥ Yes □ No	a. I have truly and accurately recorde	ed all Proposed Insureds' answers on this application.							
Certification	¥ Yes □ No		ature(s) hereon. (If "no", provide details in Special							
STOP		Instructions Section.)								
Be sure to answer	☐ Will 🗷 Will Not	c. To the best of my knowledge, the Insurance, and/or Annuities.	insurance applied for will or will not replace any Life							
all three questions.		modiance, analoi Annuites.								
	Sam A. F	Producer	X Sam A. Producer							
		Producer's Name (print)	Signature of Producer							
		,	Ü							
	Any Firm		02-A000000							
		Firm	Producer's Nationwide #							

## TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH
This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

<b>HEALTH QUESTION</b>				
	Proposed	Proposed	Λον	
STOP	Primary Insured	Additional Insured	Any Child	Has anyone here proposed for insurance:
Question must be	Yes No	Yes No	Yes No	
answered by each Proposed Insured(s).				To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	no represen	question is an tative of Nation Isurance receip	nwide Life and	or LEFT BLANK, NO COVERAGE will take effect under this Agreement and Annuity Insurance Company is authorized to accept money, and/or provide a capt
TERMS AND CONDIT		isurance receip	и то тье арртс	ant.
Amount of		nsurance unde	r this Aareem	ent will commence on the date of the application if the full first premium for the
Coverage	mode select	ted has been p	oaid and acce	epted by Nationwide or authorized by Electronic Funds Transfer as advance
[\$1,000,000] overall	payment for	an application	for Life Insura	ance. If any Proposed Insured dies while this temporary insurance is in effect,
maximum for all	Nationwide \	WIII pay to the d int of death bei	iesignated Bei nefits if anv v	neficiary the lesser of: which would be payable under the policy and its riders if issued as applied for,
applications or	excluding	any accidenta	I death benefi	ts, or
agreements.	• [\$1,000,0	001 This total b	oenefit limit ap	oplies to all insurance applied for under this and any other current applications
		wide and any d ne or more Pro		ary Insurance Agreements for Life Insurance whether applied for on the life or
Date Coverage				eement will terminate automatically on the earliest of:
Terminates	<ul> <li>60 days</li> </ul>	from the date o	f this signed A	Agreement, or
60 DAYS maximum	• the date a	any policy is off Nationwide ma	erea or issued alls notice of t	If to the Proposed Insured in connection with the above application, or ermination of coverage and refund of the advance payment to the Proposed
coverage.	Insured, o	or the Owner, if	different than	the Proposed Insured.
Limitations	Fraud or     invalidate	material misre	presentation i	n the application or in the answers to the Health question of this Agreement
	This Agree	es inis agreeme ement does no	ent and ivation of provide cove	wide's only liability is for refund of any payment made. erage for Proposed Insured's who are under 15 days of age or over the age of
	70 on the	date of the Ag	reement.	
				de, while sane or insane, Nationwide's liability under this Agreement is limited
		d of the payme		ement if the check submitted as payment is not honored by the bank on first
	presentat	ion or if the Ele	ectronic Funds	Transfer is not processed by the bank.
	No one is	authorized to	waive or modi	fy any of the provisions of this Agreement.
SIGNATURES	LILIANE DE	NEW FRA A GOE	N/ 05 AND 11	AND DEAD THIS ASSESSMENT AND DESIGNED THAT THE ANSWERS ADD
Proposed Insured(s) and	TDUE TO T	UE DEAT OF A	N / 1/N 10 1 A // E E	AVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE DGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.
Owner Signatures	Dated (mm/	dd/yyyy)July	28, 2008	X John D. Doe Signature of Proposed Primary Insured
		33331		Signature of Proposed Primary Insured
				(or parent if Proposed Primary Insured is under age 15)
	Χ	Cimatum	-f A !! 1/O	wner X Signature of Proposed Additional Insured
		Signature o <i>(if other than th</i>	of Applicant/O e Proposed In	
Initial Premium	An initial pre	mium payment	in the amoun	t of \$ has been submitted with this application. I have
Receipt and Producer's	advised the	Applicant/Own	er that addition	nal premium may need to be submitted at time of delivery.
Signature				
STOP				
Be sure to include the amount of the	\ \ \ .	Com A Direct	~~	Apy Fire-
initial premium	XS	Sam A. Produce Signature	e <u>r</u> of Producer	Any Firm 02-A000000 Firm Producer's Nationwide #
payment.		Jigilalule	or i roducel	Tillii Troudcei Sivaliofiwide #

#### NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance [P.O. Box 182835, Columbus, Ohio 43218-2835] PART A - CLIENT INFORMATION Proposed Name (First, MI, Last) SSN / Tax ID # Primary John D. Doe 000 00 - 0000 Address City Insured One Any Street Any City Zip Code County Former Name State Sex Any State 00000 Any County ×M Marital Status Age 35 Date of Birth (mm/dd/yyyy) State of Birth ■ Married □ Single □ Other 02/07/1973 OH E-Mail Address Phone #  $\square$  AM ) 000-0000 JDDOE@YAHOO.COM 000 **⋈** PM Driver's License # / State of Issue Net Worth Annual Income RL000000 OH Occupation **Employer** Citizenship (If other, submit Foreign Supplement.) □ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.? Name of Additional Proposed Relationship to Birth Birth Date Sex Height Weight SSN / Tax ID # Additional Insured(s) State Primary Insured Insured If applicable, complete for either: a) Joint Insured for Joint/Spouse Proposed Additional Insured Information Only Survivorship Life Address \(\superatorname{\text{\text{\$\text{Check box if same as Proposed Primary Insured}}\)}\) Former Name Plan; or b) Term Rider on Zip Code City State County Another Covered E-Mail Address  $\square$  AM Person (i.e., Phone #  $\square$  PM Spouse/Children) Driver's License # / State of Issue Net Worth Annual Income If additional space is required, use Citizenship (If other, submit Foreign Supplement.) Occupation **Employer** Special Instructions ☐ Canada □ U.S. Section. ☐ Other, how long have you lived in the U.S.? SSN / Tax ID # Owner Name (First, MI, Last) Complete ONLY if Address \(\subseteq\) (Check box if same as Proposed Primary Insured) City Owner is not the Proposed Primary State Zip Code County Date of Birth (mm/dd/yyyy) Phone #  $\square$  AM Insured.  $\square$  PM Unless indicated the Type of Owner Relationship to Insured E-Mail Address Proposed Primary ☐ Individual ☐ Employer ☐ Trust Insured (Joint ☐ Rabbi Trust ☐ Other Insureds in the case If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, of Survivorship) will otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The own the policy. If more than two SSN shown above will be used unless otherwise instructed. Owners are Joint Owner (First, MI, Last) SSN / Tax ID # requested, use Special Instructions Address \( \subseteq \text{(Check box if same as Proposed Primary Insured)} \) City Section. Date of Birth (mm/dd/yyyy) State Zip Code County Phone #  $\square$  AM  $\square$  PM Type of Owner Relationship to Insured E-Mail Address ☐ Individual ☐ Employer ☐ Trust TRUST - Submit a ☐ Rabbi Trust ☐ Other copy of first and signature pages of Trust Tax Date of **Exact Name of Trust** Current Trustee(s) Trust document. **ID Number** Trust

4. Contingent Owner	Name (First, MI, Last)				SS	SN / Tax ID #				
Complete this section to name an	Address \( \square\) (Check box if same	as Propos	sed Primary Insul	red)	City					
alternative Owner in the event the Insured survives the Owner.	State Zip Code Cou	nty		Relationsh	nip to Insured	Date of Birth (mm/dd/yyyy)				
5. Primary Beneficiary Designations	When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.  □ Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.									
If Survivorship Life Plan, the Proposed Insureds may not be	For Proposed Primary Insured Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
named as Beneficiary.  If additional space is required, use Special Instructions Section.	Jane S. Doe	100	Wife	10/08/1975	000-00-000	One Any Street One Any State 00000				
Secuon.										
	For Proposed Additional Insu	red								
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
/ Oanthamat	F D									
6. Contingent Beneficiary Designations	For Proposed Primary Insurer Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
If additional space is required, use Special Instructions Section.										
Sconori.	For Proposed Additional Insu	red								
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
7. Taxpayer ID	I certify under penalties of perju	ry that:								
Number	<ul> <li>The number shown on this f</li> <li>I am not subject to backup w</li> <li>I have not been notified dividends, or</li> <li>the Internal Revenue Ser</li> </ul>	orm is my controlling hat I am solution	because ubject to backupotified me that	p withholding as	a result of a	failure to report all interest or ckup withholding, or that I am				
Check box, if applicable	exempt from backup withl  I am a U.S. person (including Check this box if you have because of failure to report The Internal Revenue Service certifications required to avoid	g a U.S. re. e been no t interest o does not	sident alien). htified by the IF or dividends on require your co	ı your tax returi	٦.					



PLAN INFORMATION						
8. Life Insurance	☐ Waddell & Reed Protection VUL	□ Nationwide YourLife® Indexed UL				
Plan	☐ Waddell & Reed Accumulation VUL	□ Nationwide YourLife® Current Assumption UL				
STOP	☐ Waddell & Reed Survivorship Universal Life	☐ Nationwide YourLife® No-Lapse Guarantee UL☐ Nationwide YourLife® SUL☐				
	☐ Nationwide YourLife® 10-year Term☐ Nationwide YourLife® 15-year Term	☐ Nationwide FourLife® No-Lapse Guarantee SUL II				
The Variable Life Fund Supplement	□ Nationwide YourLife® 20-year Term	□ Nationwide YourLife® Protection VUL				
MUST be completed	□ Nationwide YourLife® 30-year Term	□ Nationwide YourLife® Accumulation VUL				
if applying for a	☐ Nationwide YourLife® 20-Pay WL	☐ Nationwide YourLife® Survivorship VUL				
Variable Product.	☐ Nationwide YourLife® WL 100	☐ Other				
The IUL Allocation Form <b>MUST</b> be	Base Specified Amount Additional Term Rider/Su	pplemental Total Specified Amount				
completed if	+ Coverage Amount (check					
applying for an Index UL Product.	availability)	Supplemental Coverage)				
inaex UL Proauci.	\$\$\$	\$ 250,000.00				
9. Additional	Death Benefit Option (If no option is selected here, Op	tion 1 is elected.)				
Options	☑ Option 1(The Specified Amount, or a multiple of the					
STOP	☐ Option 2(The Specified Amount, plus the Cash/Acc					
3101	Value, whichever is greater.)	·				
Complete this section		d Premium Account at%* interest or a multiple of the				
if you applied for a Variable Universal,		eater.) *Enter a percentage up to 12% maximum, ONLY if				
Universal or		entered or the Owner is not a business entity, 0% will apply.				
Survivorship Life	Internal Revenue Code Life Insurance Qualification Te	st Option				
Plan.	☑ Guideline Premium/Cash Value Corridor Test					
	☐ Cash Value Accumulation Test (If no selection is made here, the Guideline Premium/Cash	Value Corridor Test is elected				
10. Optional		·				
Benefits	Variable or Universal Life Plans Only (Subject to Plan	□ Change of Insured Rider				
Check Plan for	☐ Spouse Rider\$\$ ☐ Children's Term Insurance Rider\$	☐ Other Rider(s)				
Availability.	☐ Long Term Care Rider*\$	☐ Other Rider(s)				
-	*Complete Supplement for Long Term Care Rider.	Can select only one:				
	☐ Accidental Death Benefit Rider \$	☐ Premium Waiver Rider\$				
	☐ Adjusted Sales Load Rider%	☐ Waiver of Monthly Deductions Rider				
	(in whole percentages only) waived for years  ☐ Extended Death Benefit Guarantee Rider	Can select only one:				
	Guarantee Percentage (Indicate percentage of	F ☐ Surrender Value Enhancement Benefit				
	specified amount)	☐ Conditional Return of Premium Rider (cannot be				
	Guarantee Duration (Indicate number of years)	elected with Extended Death Benefit Guarantee Rider)				
	Survivorship Variable or Survivorship Universal Life P	lans Only (Subject to Plan availability.)				
	☐ Four Year Term Rider** \$	☐ Policy Split Option Rider				
'	**If the No Charge Four Year Term Insurance has	☐ Other Rider(s)				
	been illustrated you should NOT select this rider.	☐ Other Rider(s)				
	Whole or Term Life Plans Only (Subject to Plan available)	bility.)				
	☐ 20 Year Spouse Rider\$\$	☐ Owner's Waiver of Premium Death or Disability Benefit				
	☐ Children's Term Insurance Rider \$	Rider (Complete Part B for the Owner)				
	☐ Accidental Death Benefit Rider \$	Occupation				
	☐ Guaranteed Insurability Benefit Rider \$	Height				
	☐ Waiver of Premium Disability Benefit Rider☐ Owner's Waiver of Premium Death Benefit Rider	Weight State of Birth				
	(Complete Part B for the Owner)					
	Occupation	☐ Other Rider(s) ☐ Other Rider(s)				
	Height	☐ Other Rider(s)				
	Weight	Suior rador(3)				
	State of Birth					
		otion (APL) for Whole Life Plans only, if available, unless				
	the box below is checked.	-				
	□ No. do not issue with ADI					



FUTURE BILLING AN	ID PREMIUM INFO	RMATION							
11. Amount Paid		w Temporary Ins	urance Agreer	ment to verif	y if the Proposed	Insured	qualifies to submi	t premium with	
With	the application.)	mount with annlia	ation				¢		
Application Check the	(NOTE: Make all								
applicable option	Moh Pomittan	co payable	to IVATIONVII	DE.)			\$		
and indicate the					and complete Sec				
premium amount					oremium amount a				
being submitted with									
the application.  12. Future Billing	Billing Options:				Payment Options				
and Payment	☐ Monthly EFT*		\$		☐ Single Premiu	m	\$		
Options	*If selected, comp			nic Draft	☐ Billing Advanta	ane	 \$		
Check the	Authorization.	ilete Section 15, n	norming Liceuro	IIIC DIAIL	Δccount Numb	ner	Ψ		
applicable billing or			\$		Account Numb  ☐ 1035 Exchang	.сі <u> </u>	\$		
payment option(s)	☐ Semi-Annual.	☐ Quarterly\$\$				· · · · · · · · · · · · · · · · · · ·	\$\$		
and indicate the premium amount.	☐ Annual						Ψ		
13. Electronic	13a. Monthly El								
Draft	Monthly Draft Da			Draft Optio	ns.				
Authorization	(NOTE: Monthly				ng - Use informa	tion on th	e initial premium c	heck.	
	based upon polic				ng - (Provide a p				
	is requested abo		nicss a day	□ *Saving:	s - (Provide a let	tter from t	he bank indicating t		
	<i>,</i>	Transmit/ABA number, Account number and Account Holder's name.)							
		13b. If no check or deposit slip provided, indicate below the bank information to be used:							
	Financial Institution	inancial Institution Name							
	Account Number				Type of Account:	□ *C	hecking □ *Sa	avings	
		financial institut	ion name and	account inf	formation, I hereb				
				o my check	king/savings acco	ount indic	cated above and	the Financial	
	Institution to deb			!-  - !    f-	4h	. 4la !a .a a !!			
14. Payor	Name <i>(First, MI, .</i>		(S) or the Own	er is billed ic	or the premium for	triis poite	.у.		
	-	Lasty							
	Address				City	State	Zip Code		
INSURANCE INFORM	MATION								
15. Replacement	☐ Yes <b>⋈</b> No	a Do you have	any other Life	Insurance	or Annuities eithe	r current	v in force or that	has heen sold	
and Other	_ 103 _ 100		ty? <i>(If "yes", li</i> .		or runnances chine	i carronn	y in force of that	nas been sola	
Policy	☐ Yes <b>区</b> No				ge now applying f	or Life In	surance or Annuit	ies with anv	
Information					of Company, amo				
STOP									
Be sure to answer	☐ Yes <b>区</b> No	c. Will any Life	Insurance or	Annuities for	or this or any oth	ner comp	any be replaced,	discontinued,	
all questions. If		reduced or o	hanged if insu	urance now	applied for is issu	ued? <i>(li</i>	f "yes", list below	and complete	
applicable, check		appropriate r	eplacement for	rms. If this i	s an IRC Sect 103	35 Excha	nge, attach 1035 i	forms.)	
the appropriate box.	☐ Yes 🗷 No				ige had Life Insura				
				yes", provide	e name of Compa	ny, face	amount and reaso	on coverage is	
		no longer in l	force.)						
		Policy	Amount Of	Year	To Be	1035	Lapsed/	Nationwide	
Insured	Company	Number	Coverage	Issued	Replaced	Exch	Surrendered/ Sold	Term Conversion	
					-		Joiu	COLIVEISION	
			\$		☐ Yes ☐ No				
			\$		☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ No☐ Yes ☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ No☐ N				

FINANCIAL INFORMA	ATION								
16. Financial Questions Explain all "yes" answers in Section	Trustee, if of		d Insured(s). Fo	osed Insured and Ownor or each <i>yes</i> answer, etails.	Proposed Primary Insured	Proposed Additional Insured	Owner/ Trustee if other than Proposed Insured(s)		
17 Details box below unless			, ,		Yes No	Yes No	Yes No		
instructed otherwise.	policy to a		npany, trust, limite	of selling or assigning thi ed liability corporation,					
This section needs to be completed by each Proposed	b. Have you sale or as	entered into any ag ssignment of this po	reement, or mad licy to a life settle	e arrangements, for the ment company, trust, ondary market purchaser'	?				
Insured and Owner/ Trustee, if other than Proposed	c. Have you assignme	been involved in arent of this policy to a	ny communication life settlement co	n about the possible sale ompany, trust, limited y market purchaser?					
Insured(s).	d. Have you	ever sold any life ir , trust, limited liabilit							
	e. Will any p	ortion of the current	or future premium	for this policy be finance	d? 🗆 🗷				
	f. Will any Ir the insura	nsured or Policy Ow ance issued on the b	ner receive any p	th 🗆 🗷					
17. Explanation of Financial Details	Question Letter	Person	Dates		Details				
If more space is									
needed, an additional blank sheet may be									
attached. Any Proposed Insured(s) or Owner(s) should									
sign and date additional pages.									
PART B - PERSONAL									
18. Tobacco Use All questions are to	Have you us nicotine in a 1. In the last		Propo	osed Primary Insured	•	Proposed Additional Insured  Yes  No			
be answered by each Proposed Insured.	2. In the last			te last used	If "yes", da	If "yes", date last used			
STOP		3	If "yes", da	te last used	If "yes", da	te last used	☐ Cigars		
Be sure to answer this section.		heck all forms of pr nicotine products		g Tobacco □ Pipe obacco □ Snuff e Products (gum, patch, e	☐ Cigareti☐ Chewin☐ Other T	g Tobacco 🏻 🛭	⊒ Pipe ⊒ Snuff		
19. Physical Measurements	Height	Current Weight	Weight 1 Yea Ago	Reas	on for Weight C	Sain or Loss			
Fill in information for the Proposed Primary Insured.									
20. Personal Physicians	N. CD	151	Proposed Pr Insured		d Additional sured	Any (	Child		
If Child Rider coverage is	Name of Pers Address:	sonal Physician:							
requested, use Special Instructions	Telephone N	umber.							
Section to add Personal Physician	Date last con								
information for each	Reason last of	consulted:							
child.	Treatment given medication property								



21. Personal Details	All questions are to be answered by each Proposed Insured. For each yes answer, indicate the appropriate item(s) and provide details.				Prop Prin Insu	nary	Proposed Additional Insured		Any Child	
Explain all "yes"	) Joe and it	,a.oato ao app. op.	(0)	.a provide detaile.	Yes	No	Yes	No	Yes	No
answers in Section 22 Details box below unless instructed otherwise.	applicati	u ever had any applica ion for reinstatement fo ed, rated-up or limited?	r Life or Health	Health Insurance <i>(or any Insurance)</i> declined,		×				
	b. Have you ever applied for or received disability payments for any illness or injury?					×				
	c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping, soaring, or ballooning? (If "yes", complete an Aviation/ Hazardous Activities Questionnaire.)					×				
	been cor	u ever had your driver's nvicted of driving while en convicted of more tl		×						
	Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If "yes", complete Drug Questionnaire.)									
	f. Have you	u ever been charged w	ith a violation o	f any criminal law?		×				
	g. In the next 12 months, do you plan to travel or reside outside of the United States or Canada? (If "yes", complete Supplement for Foreign Nationals or Travel.)									
	h. Do you belong to or intend to join any active or reserve military or naval organization? (If "yes", complete Military Status Questionnaire.)					×				
	i. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?					×				
	j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If "yes", provide relationship to Proposed Insured(s), age at death, and cause of death, and if cancer, provide type.)					×				
22. Explanation of Personal	Question Letter	Person	Dates		Det	ails				
Details  If more space is needed, an additional										
blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should										
sign and date additional pages.										

#### **HEALTH INFORMATION** Proposed Proposed 23. Health To the best of your knowledge and belief, has anyone here proposed Any Primary Additional Questions for insurance ever consulted a licensed health care provider for, been Child Insured Insured treated for, taken medication for, or been diagnosed as having: All questions are to Yes No Yes No Yes No be answered by a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-× each Proposed related condition, or received a positive result of an HIV (Human Insured. Immunodeficiency Virus) test? Explain all "yes" Heart disease including heart attack, angina, or other chest pain, × П answers in Section cardiomyopathy, shortness of breath, congestive heart failure, heart 24 Details box murmur, or other disorder of the heart? unless instructed c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, × otherwise. or high triglycerides? Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, × peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism? × e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, П Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder? f. Depression, neurosis, affective disorder, psychosis, or any other mental × or emotional disorder? Asthma, emphysema, chronic bronchitis, tuberculosis, or any other × disease of the lungs or respiratory system? × h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract? Sugar, protein or blood in the urine, kidney stones, sexually transmitted × disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system? Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, × or thyroid? Disorder of the blood including anemia, sickle cell disorders, × thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors? Cancer, or any malignant or benign tumor or cyst, or any chronic × disease of the skin or lymph glands? m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic × back or muscle condition? n. Alcoholism, narcotic addiction, drug use, or hallucinations? × П × o. Any disease or disorder of the eyes, ears, nose or throat? П П To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance: p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.) q. Had any disease, disorder, injury, or operation not already disclosed on П × this application? r. Had any x-rays, electrocardiograms, or other medical tests for reasons × not already disclosed on this application? Been medically advised to have any surgery, hospitalization, treatment × or test that was not completed or results that you have not received? Currently taking any medication other than indicated above to include × prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.) Used alcoholic beverages? (If yes, how much, what kind (beer, wine, × liquor), and how often?)



			1	D.1.9.							
24. Details of Health History	Question Letter	Person	Dates	Details (Be specific. Give full names, addresses and telephone numbers (if available) of physicians, hospitals, etc.)							
If more space is needed, an additional				(ii available) oi priysiciaris, riospitais, etc.)							
blank sheet may be											
attached. Any Proposed Insured(s)											
or Öwner(s) shouÌd											
sign and date additional pages.											
	16 112 112 112 112			and the short Ann Dran and Income (short of Come (short of Sings and date							
25. Special Instructions Section		lf more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.									
DADT C FDAUD CT	ATEMENTS /		TICEC								
PART C – FRAUD ST WYOMING only:				n containing a false or deceptive statement, and does so with intent to							
•	defraud or ki	nowing that he/she is	facilitating a fra	ud against an insurer, may be guilty of insurance fraud.							
ARKANSAS and RHODE ISLAND	false informa	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents alse information in an application for insurance is guilty of a crime and may be subject to fines and confinement in									
only: COLORADO only:	prison.	prison.									
	FACTS OR ATTEMPTIN INSURANCI WHO KNO' POLICYHOI POLICYHOI PROCEEDS OF REGULA	IMPORTANT NOTICE – IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.									
Pre-Notice of	This notice insurance:	s to inform you that	as part of our i	normal underwriting procedures in connection with an application for							
Procedures as Required by	<ul> <li>An invest</li> </ul>	igative consumer rep	ort may be ma	de whereby information is obtained through personal interviews with							
The Fair Credit	your neig general r	hbors, friends or othe eputation, personal c	rs with whom yo haracteristics a	ou are acquainted. This inquiry will include information as to character, and mode of living, except as may be related directly or indirectly to							
Reporting Act	your sexu	uál orientation, with r	espect to you,	members of your family, and others having an interest in or closely							
of 1970	<ul> <li>You may</li> </ul>	d with the insurance to elect to be interviewe	ed if an investig	ative consumer report is prepared in connection with this application.							
				tigative consumer report by submitting your request in writing. sonable time after you receive this notice, additional information as to							
	the nature for additi Columbus	e and scope of the in onal information add s, Ohio 43218-2835l.	vestigation, if or ressed to Nati In the event of	ne is made, will be provided. You may send corrections and requests conwide Life and Annuity Insurance Company, [P.O. Box 182835, an adverse decision, you will be notified in writing.							
Medical	Information i	egarding your insural	oility will be trea	ted as confidential. Nationwide Life and Annuity Insurance Company, ef report thereon to the Medical Information Bureau, a non-profit							
Information Bureau Disclosure Notice	membership	organization of life	insurance com	npanies, which operates an information exchange on behalf of its							
DISCIDSULE MOUCE				mber company for life or health insurance coverage or a claim for reau, upon request, will supply such company with the information in							
	its file. Upo	n receipt of a request	from you, the	Bureau will arrange disclosure of any information it may have in your							
	in accordance	ce with the procedure	es set forth in t	n the Bureau's file, you may contact the Bureau and seek a correction he Federal Fair Credit Reporting Act. The address of the Bureau's							
	information (	office is [50 Braintree	Hill, Suite 400	, Braintree, Massachusetts 02184-8734, telephone number 866-692- of the Bureau's information office is www.mib.com. Nationwide Life							
	and Annuity	Insurance Company	or its reinsure	er(s) may also release information in its file to other life insurance lth insurance, or to whom a claim for benefits may be submitted.							

PART D – AGREEME	INT, AUTHORIZATIO	N AND SIGNATURE					
Agreement	I understand and ag	ree that:	and the Dellacer				
	<ul> <li>Inis application, are the basis of a</li> </ul>	any amendments to it, and any related t any insurance issued upon this applicatio	medical examination(s) will become a part of the Policy and				
	<ul> <li>The Proposed In</li> </ul>	isured or Owner has a right to cancel t	his application at any time by contacting their producer or				
	Nationwide in wr	titing. No producer, medical examiner	or other representative of Nationwide may accept risks or				
	make or change	any contract; or waive or change any of	the Company's rights or requirements. rary Insurance Agreement, Nationwide will only be liable to				
		th in that Agreement.	rally insurance Agreement, Nationwide will only be liable to				
	<ul> <li>If the full first pr</li> </ul>	emium is not paid with this application	, then insurance will only take effect when (1) a policy is				
	issued by Nation	nwide and accepted by me; and (2) the	ne full first premium is paid; and (3) all the answers and				
	and helief when i	e on the application, medical examination (1) and (2) have occurred.	n(s) and amendments are true to the best of my knowledge				
Authorization	I authorize: any lice	ensed physician or medical practitioner	r, any hospital, clinic, any pharmacy or pharmacy benefit				
	managers, and oth	er sources who maintain prescription o	drug records and related information, or other medical or				
	institution or persor	acility; ally illisulatice company; the land to disclose any information concerning	Medical Information Bureau; or any other organization, gme, including, but not limited to, my entire medical/health				
	record to the Medic	cal Director of Nationwide Life and Ann	uity Insurance Company or its affiliates, including, but not				
	limited to, RSA Me	edical, for the purpose of underwriting	my application in order to determine eligibility for Life				
	restrict my protected	ivestigate claims. By my signature be I health information do not apply to this:	low, I acknowledge that any agreements I have made to form; and Linstruct any physician; health care professional:				
	hospital; clinic; phar	macy or pharmacy benefit managers; m	form; and I instruct any physician; health care professional; nedical facility, or other health care provider to release and				
	disclose my entire	medical/health record without restriction	on. I understand that any information that is disclosed				
	confidentiality of he	alth information. This form, or a copy of	per be covered by federal rules governing privacy and it, will be valid for a period of not more than two years (24				
	months) from the da	ate it was signed. I understand that I h	ave the right to revoke this form in writing, at any time, by				
	sending a written re	equest for revocation to Nationwide Life a Columbus Objo 43218-2835] Lunderst	and Annuity Insurance Company, [Attention: Underwriting, and that a revocation is not effective to the extent that any				
	of my providers have	re relied on this form; or to the extent th	nat Nationwide Life and Annuity Insurance Company has a				
	legal right to contest	t a claim under an insurance policy or to	contest the policy itself. I further understand that if I refuse				
	to sign this form to i	release my complete records, or, il i rev surance Company may not he able to	oke this authorization before a policy is issued, Nationwide				
	representative or I h	have a right to a copy of this form by send	process my application. I understand that my authorized ding a request to Nationwide in writing.				
Proposed	I HAVE READ THIS	S APPLICATION AND AGREEMENT AN	ND DECLARE THAT THE ANSWERS ARE TRUE TO THE				
Insured(s) and	BEST OF MY KNO	WLEDGE AND BELIEF. I UNDERSTAN	D AND AGREE TO ALL ITS TERMS.				
Owner/Trustee							
Signatures	Signed at	Any City, Any State	, on July 28 , 2008				
STOP		City/State	Month/Day Year				
All Financial		John D. Doo	V John D. Doo				
questions in Section	Full Name o	John D. Doe f Proposed Primary Insured <i>(print)</i>	X <u>John D. Doe</u> Signature of Proposed Primary Insured				
16 (a through f) are	T ull Name o	i i roposed i filmary insured (prim)	(or parent if Proposed Primary Insured is under age 15)				
required to be			(er parent in troposed trimary insured is under age to)				
answered for both the Proposed			X				
Insured(s) and	Full Name of	Proposed Additional Insured (print)	Signature of Proposed Additional Insured				
Owner, if not			(if to be Insured)				
Proposed	X		X				
Insured(s).		nature of Applicant/Owner	Signature of Applicant/Owner				
		than the Proposed Insured(s))	(if other than the Proposed Insured(s))				
PART E - PRODUCE	R'S CERTIFICATION						
Producer's	✓ Yes □ No		ed all Proposed Insureds' answers on this application.				
Certification	✓ Yes □ No		ature(s) hereon. (If "no", provide details in Special				
STOP		Instructions Section.)					
Do ouro to onouver	☐ Will <b>또</b> Will Not		insurance applied for will or will not replace any Life				
Be sure to answer all three questions.		Insurance, and/or Annuities.					
an un oo quosiions.							
	C A . [	Dun de en en	V Com A Dradwood				
	Sam A. F	Producer Producer's Name <i>(print)</i>	X <u>Sam A. Producer</u> Signature of Producer				
		Toducer's Ivalle (print)	Signature of Froudter				
	Any Firm		02-A000000				
		Firm	Producer's Nationwide #				
	1						

## TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH
This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION									
	Proposed	Proposed	Λny						
STAP	Primary	Additional	Any Child	Has anyone here proposed for insurance:					
	Insured Yes No	Insured Yes No	Yes No	Tias arryone here proposed for insurance.					
Question must be				To the best of your knowledge and belief, within the past 10 years, been					
answered by each Proposed Insured(s).				treated for, consulted a licensed health care provider, or been diagnosed by					
r roposcu irisurcu(s).				a licensed health care provider as having: angina, or chest pain or					
				discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-					
				related disorder or positive HIV (Human Immunodeficiency Virus) test result;					
				any brain, nervous, or mental disorder, any drug or alcohol addiction; any					
				kidney disorder (other than kidney stones); or any cancer or other					
	If the above	auestion is an	swered <b>YES</b> (	malignancy? or LEFT BLANK, NO COVERAGE will take effect under this Agreement and					
	no represent	tative of Nation	wide Life and	Annuity Insurance Company is authorized to accept money, and/or provide a					
temporary insurance receipt to the applicant.									
	TERMS AND CONDITIONS								
Amount of	mode select	nsurance unue ed has been r	r this Agreeme aid and acce	ent will commence on the date of the application if the full first premium for the epted by Nationwide or authorized by Electronic Funds Transfer as advance					
Coverage	payment for	an application	for Life Insura	ance. If any Proposed Insured dies while this temporary insurance is in effect,					
[\$1,000,000] overall maximum for all	Nationwide v	vill pay to the d	esignated Ber	neficiary the lesser of:					
applications or				which would be payable under the policy and its riders if issued as applied for,					
agreements.	• [\$1,000,Ŏ	excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for any the life or							
		to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.							
Date Coverage				eement will terminate automatically on the earliest of:					
Terminates	• 60 days f	60 days from the date of this signed Agreement, or							
	• the date a	the date any policy is offered or issued to the Proposed Insured in connection with the above application, or							
60 DAYS maximum coverage.		the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.							
Limitations	<ul> <li>Fraud or</li> </ul>	Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement							
	invalidate	s this Agreeme	nt and Nation	wide's only liability is for refund of any payment made.					
		ement does no date of the Ag		erage for Proposed Insured's who are under 15 days of age or over the age of					
	<ul> <li>If any Pro</li> </ul>	posed Insureď	dies by suicion	de, while sane or insane, Nationwide's liability under this Agreement is limited					
		d of the payme		and the short artists of a compatible of the short of the					
	Inere is i     nresentat	no coverage ur ion or if the Fle	naer inis Agre etronic Funds	ement if the check submitted as payment is not honored by the bank on first Transfer is not processed by the bank.					
				fy any of the provisions of this Agreement.					
SIGNATURES				, , , , , , , , , , , , , , , , , , ,					
Proposed	I HAVE REC	CEIVED A COP	Y OF AND H	AVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE					
Insured(s) and	TRUE TO TH	HE BEST OF M	IY KNOWLED	OGE AND BELIEF. TUNDERSTAND AND AGREE TO ALL ITS TERMS.					
Owner Signatures	Dated (mm/d	<i>dd/yyyy</i> ) <u>July</u>	28, 2008	X John D. Doe Signature of Proposed Primary Insured					
				Signature of Proposed Primary Insured  (or parent if Proposed Primary Insured is under age 15)					
	V			, , , , , , , , , , , , , , , , , , , ,					
	X	Signature o	of Applicant/O	wner X Signature of Proposed Additional Insured					
	(	if other than th							
Initial Premium	An initial pre	mium payment	in the amoun	t of \$ has been submitted with this application. I have					
Receipt and	advised the	Applicant/Owne	er that additior	nal premium may need to be submitted at time of delivery.					
Producer's									
Signature									
STOP									
Be sure to include									
the amount of the initial premium	XS	Sam A. Produce	of Droduces	Any Firm 02-A000000  Firm Droducer's Nationwide #					
payment.		Signature	of Producer	Firm Producer's Nationwide #					

#### NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance [P.O. Box 182835, Columbus, Ohio 43218-2835] PART A - CLIENT INFORMATION Proposed Name (First, MI, Last) SSN / Tax ID # Primary John D. Doe 000 00 - 0000 Address City Insured One Any Street Any City Zip Code County Former Name State Sex Any State 00000 Any County ×M Marital Status Age 35 Date of Birth (mm/dd/yyyy) State of Birth ■ Married □ Single □ Other 02/07/1973 OH E-Mail Address Phone #  $\square$  AM ) 000-0000 JDDOE@YAHOO.COM 000 **⋈** PM Driver's License # / State of Issue Net Worth Annual Income RL000000 OH Occupation **Employer** Citizenship (If other, submit Foreign Supplement.) □ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.? Name of Additional Proposed Relationship to Birth Birth Date Sex Height Weight SSN / Tax ID # Additional Insured(s) State Primary Insured Insured If applicable, complete for either: a) Joint Insured for Joint/Spouse Proposed Additional Insured Information Only Survivorship Life Address \(\superatorname{\text{\text{\$\text{Check box if same as Proposed Primary Insured}}\)}\) Former Name Plan; or b) Term Rider on Zip Code City State County Another Covered E-Mail Address  $\square$  AM Person (i.e., Phone #  $\square$  PM Spouse/Children) Driver's License # / State of Issue Net Worth Annual Income If additional space is required, use Citizenship (If other, submit Foreign Supplement.) Occupation **Employer** Special Instructions ☐ Canada □ U.S. Section. ☐ Other, how long have you lived in the U.S.? SSN / Tax ID # Owner Name (First, MI, Last) Complete ONLY if Address \(\subseteq\) (Check box if same as Proposed Primary Insured) City Owner is not the Proposed Primary State Zip Code County Date of Birth (mm/dd/yyyy) Phone #  $\square$  AM Insured.  $\square$  PM Unless indicated the Type of Owner Relationship to Insured E-Mail Address Proposed Primary ☐ Individual ☐ Employer ☐ Trust Insured (Joint ☐ Rabbi Trust ☐ Other Insureds in the case If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, of Survivorship) will otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The own the policy. If more than two SSN shown above will be used unless otherwise instructed. Owners are Joint Owner (First, MI, Last) SSN / Tax ID # requested, use Special Instructions Address \( \subseteq \text{(Check box if same as Proposed Primary Insured)} \) City Section. Date of Birth (mm/dd/yyyy) State Zip Code County Phone #  $\square$  AM  $\square$  PM Type of Owner Relationship to Insured E-Mail Address ☐ Individual ☐ Employer ☐ Trust TRUST - Submit a ☐ Rabbi Trust ☐ Other copy of first and signature pages of Trust Tax Date of **Exact Name of Trust** Current Trustee(s) Trust document. **ID Number** Trust

4. Contingent Owner	Name (First, MI, Last)				SSN / Tax ID #					
Complete this section to name an	Address \( \square\) (Check box if same	as Propos	sed Primary Insul	red)	City					
alternative Owner in the event the Insured survives the Owner.	State Zip Code Cou	nty		Relationsh	nip to Insured	Date of Birth (mm/dd/yyyy)				
5. Primary Beneficiary Designations	When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.  □ Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.									
If Survivorship Life Plan, the Proposed Insureds may not be	For Proposed Primary Insured Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
named as Beneficiary.  If additional space is required, use Special Instructions Section.	Jane S. Doe	100	Wife	10/08/1975	000-00-000	One Any Street One Any State 00000				
Secuon.										
	For Proposed Additional Insu	red								
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
/ Oanthamat	F D									
6. Contingent Beneficiary Designations	For Proposed Primary Insurer Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
If additional space is required, use Special Instructions Section.										
Sconori.	For Proposed Additional Insu	red								
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s	Share	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID#	Address				
7. Taxpayer ID	I certify under penalties of perju	ry that:								
Number	<ul> <li>The number shown on this f</li> <li>I am not subject to backup w</li> <li>I have not been notified dividends, or</li> <li>the Internal Revenue Ser</li> </ul>	orm is my controlling hat I am solution	because ubject to backupotified me that	p withholding as	a result of a	failure to report all interest or ckup withholding, or that I am				
Check box, if applicable	exempt from backup withl  I am a U.S. person (including Check this box if you have because of failure to report The Internal Revenue Service certifications required to avoid	g a U.S. re. e been no t interest o does not	sident alien). htified by the IF or dividends on require your co	ı your tax returi	٦.					



PLAN INFORMATION	L								
8. Life Insurance		Performance VUL - Protection	☐ Natio	nwide YourLife® SUL					
Plan		Performance VUL - Accumulation	on   🗆 Nation	nwide YourLife® No-Lapse Guarantee SUL II					
	<ul><li>□ Nationwide Marathon<sub>SM</sub> I</li><li>□ Nationwide Marathon<sub>SM</sub> I</li></ul>			nwide YourLife® 20-Pay WL nwide YourLife® WL 100					
STOP	☐ Nationwide YourLife® Pro			nwide YourLife® 10-year Term					
The Variable Life	☐ Nationwide YourLife® Ac		☐ Nationwide YourLife® 15-year Term						
Fund Supplement	☐ Nationwide YourLife® Su	urvivorship VUL	☐ Nationwide YourLife® 20-vear Term						
MUST be completed	☐ Nationwide YourLife® Cu	urrent Assumption UL	☐ Nationwide YourLife® 30-year Term						
if applying for a Variable Product.	☐ Nationwide YourLife® No		☐ Other	<u> </u>					
The IUL Allocation	□ Nationwide YourLife® Inc		nnlomontol	Total Creatified Amount					
Form <b>MUST</b> be	Base Specified Amount	Additional Term Rider/Su		Total Specified Amount					
completed if		+ Coverage Amount <i>(check</i>	ріан ю	= (including Additional Term Rider/					
applying for an Index UL Product.		availability)		Supplemental Coverage)					
maex of Product.	\$ 250,000.00	\$		\$ 250,000.00					
<ol><li>Additional</li></ol>	Death Benefit Option (If n	no option is selected here, Opt	tion 1 is electe	ed.)					
Options	■ Option 1(The Specif	fied Amount, or a multiple of the	Cash/Accumu	llated Value, whichever is greater.)					
STOP	☐ Option 2(The Specif	Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated							
	Value, whic	chever is greater.)							
Complete this section				ount at%* interest or a multiple of the					
if you applied for a				a percentage up to 12% maximum, ONLY if					
Variable Universal, Universal or				Owner is not a business entity, 0% will apply.					
Survivorship Life		fe Insurance Qualification Tes	st Option						
Plan.	■ Guideline Premium/Casł	h Value Corridor Test							
	☐ Cash Value Accumulation								
		re, the Guideline Premium/Cash		r Test is elected.)					
10. Optional		Plans Only (Subject to Plan a	vailability.)						
Benefits	☐ Spouse Rider	\$		f Insured Rider					
Check Plan for	☐ Children's Term Insuran	nce Rider \$	□ Other Rid						
Availability.	☐ Long Term Care Rider*.		☐ Other Rid	er(s)					
		for Long Term Care Rider.	Can select of	only one:					
	☐ Accidental Death Benefi		□ Premium Waiver Rider\$						
	☐ Adjusted Sales Load Ric		☐ Waiver of	Monthly Deductions Rider					
	(in whole percentages of ☐ Extended Death Benefit		Can select of	only one:					
		entage (Indicate percentage of		Value Enhancement Benefit					
	specified amount			al Return of Premium Rider (cannot be					
		ion (Indicate number of years)	elected w	ith Extended Death Benefit Guarantee Rider)					
		Survivorship Universal Life Pl	ans Only (Sui	bject to Plan availability.)					
	☐ Four Year Term Rider**.	\$_	☐ Policy Spli	it Option Rider					
!	**If the No Charge Four	r Year Term Insurance has	☐ Other Rid	er(s)					
	been illustrated you sho	ould NOT select this rider.	□ Other Rid	er(s)					
		Only <i>(Subject to Plan availab</i>	ility.)						
		\$	☐ Owner's \	Naiver of Premium Death or Disability Benefit					
	☐ Children's Term Insuran	nce Rider \$	Rider (Co	omplete Part B for the Owner)					
	☐ Accidental Death Benefit	it Rider \$	Occupation	on					
	☐ Guaranteed Insurability B		Height						
	☐ Waiver of Premium Disa		Weight						
	☐ Owner's Waiver of Prem		State of E	Birth					
	(Complete Part B for the			er(s)					
	Occupation		□ Other Rid	er(s)					
	Height		☐ Other Rid	er(s)					
	vveight								
,	State of Birth	<del></del>							
			tion (APL) for	Whole Life Plans only, if available, unless					
	the box below is checked.								
	│ □ No. do not issue with A	API							

FUTURE BILLING AN	ID PREMIUM INFO	ORMATION								
11. Amount Paid		w Temporary Ins	surance Agreei	ment to verii	fy if the Proposed	Insured	qualifies to subm	it premium with		
With	the application.)									
Application							\$			
Check the	(NOTE: Make al	I checks payable	to <b>NATIONWI</b>	DE.)						
applicable option										
and indicate the premium amount					and complete Sec					
being submitted with	☐ Draft initial pa	yment and future	payments (ind	licate initial p	oremium amount a	nd comp	lete			
the application.	Sections 12 &	13)					\$			
12. Future Billing	Billing Options:				Payment Options					
and Payment	☐ Monthly EFT*		\$		☐ Single Premiu	m	\$			
Options	_	plete Section 13, I			☐ Billing Advanta	age	\$			
Check the	Authorization.	•	,		Account Numb	oer Oer				
applicable billing or	☐ Quarterly		\$		Account Numb  ☐ 1035 Exchang	е	\$			
payment option(s) and indicate the	☐ Semi-Annual.		\$		☐ Other	• • • • • • • • • • • • • • • • • • • •	\$ *			
premium amount.					_ 0		Ψ			
13. Electronic		13a. Monthly Electronic Draft Options:								
Draft				Droft Optio	anc.					
Authorization		y (1 <sup>st</sup> – 28 <sup>th</sup> ):		Draft Option	ng – Use informa	tion on th	o initial promium o	hock		
7.0		Draft Day will be			ing - Ose illioitha ing - (Provide a p			HCCK.		
		cy effective date u	iniess a day		s - (Provide a lei			t <b>h</b> e		
	is requested abo	Transmit/ABA number, Account number and Account Holder's name.)								
	13b. If no check	3b. If no check or deposit slip provided, indicate below the bank information to be used:								
		Financial Institution Name Transit/ABA Number								
		Account Number					heckina □*S	avings		
	Account Number Type of Account:   *By providing my financial institution name and account information, I hereby authorize No									
					king/savings acco					
		oit the same such		o my onco	ung/savings acco	ant man	alea above and	tric i mariotar		
14. Payor				er is billed fo	or the premium for	this polic	CV.			
· ·· · · · · · · · · · · · · · · · · ·	Name (First, MI,		. ,		•	,				
	Address				City		State	Zip Code		
	Addiess				City	State	Zip Code			
INSURANCE INFORM	MATION						<u> </u>	· ·		
15. Replacement	☐ Yes <b>区</b> No	a. Do vou have	any other Life	e Insurance	or Annuities eithe	r current	v in force or that	has been sold		
and Other			ty? <i>(If "yes", li</i> i				<i>j</i>			
Policy	☐ Yes <b>区</b> No				ige now applying f	or Life In	surance or Annui	ties with any		
Information		other compar	ny? <i>(If "yes", p</i>	rovide name	of Company, amo	unt appli	ed for and purpos	e of coverage.)		
STOP		'	<i>y</i> ( <i>y</i> ) / (		7 5.	,,	, ,	3 /		
	☐ Yes <b>区</b> No	c. Will any Life	Insurance or	Annuities f	or this or any oth	er comp	any be replaced	discontinued.		
Be sure to answer all questions. If					applied for is issued					
applicable, check					is an IRC Sect 103					
the appropriate box.	☐ Yes <b>区</b> No				age had Life Insura					
					e name of Compa					
		no longer in l		, , ,	,	<i>J</i> ,		3		
			T		T D	4005	Lapsed/	Nationwide		
Insured	Company	Policy Number	Amount Of		To Be	1035	Surrendered/	Term		
	' '	Number	Coverage	Issued	Replaced	Exch	Sold	Conversion		
			\$		☐ Yes ☐ No					
			\$		☐ Yes ☐ No					
	1	+		-	1		<b>†</b>			
		\$ DV00 DM0 D								
			\$		☐ Yes ☐ No					

FINANCIAL INFORMA	ATION								
16. Financial Questions Explain all "yes" answers in Section	Trustee, if of		d Insured(s). Fo	osed Insured and Ownor or each <i>yes</i> answer, etails.	Proposed Primary Insured	Proposed Additional Insured	Owner/ Trustee if other than Proposed Insured(s)		
17 Details box below unless			, ,		Yes No	Yes No	Yes No		
instructed otherwise.	policy to a		npany, trust, limite	of selling or assigning thi ed liability corporation,					
This section needs to be completed by each Proposed	b. Have you sale or as	entered into any ag ssignment of this po	reement, or mad licy to a life settle	e arrangements, for the ment company, trust, ondary market purchaser'	?				
Insured and Owner/ Trustee, if other than Proposed	c. Have you assignme	been involved in arent of this policy to a	ny communication life settlement co	n about the possible sale ompany, trust, limited y market purchaser?					
Insured(s).	d. Have you	ever sold any life ir , trust, limited liabilit							
	e. Will any p	ortion of the current	or future premium	for this policy be finance	d? 🗆 🗷				
	f. Will any Ir the insura	nsured or Policy Ow ance issued on the b	ner receive any p	th 🗆 🗷					
17. Explanation of Financial Details	Question Letter	Person	Dates		Details				
If more space is									
needed, an additional blank sheet may be									
attached. Any Proposed Insured(s) or Owner(s) should									
sign and date additional pages.									
PART B - PERSONAL									
18. Tobacco Use All questions are to	Have you us nicotine in a 1. In the last		Propo	osed Primary Insured	•	Proposed Additional Insured  Yes  No			
be answered by each Proposed Insured.	2. In the last			te last used	If "yes", da	If "yes", date last used			
STOP		3	If "yes", da	te last used	If "yes", da	te last used	☐ Cigars		
Be sure to answer this section.		heck all forms of pr nicotine products		g Tobacco □ Pipe obacco □ Snuff e Products (gum, patch, e	☐ Cigareti☐ Chewin☐ Other T	g Tobacco 🏻 🛭	⊒ Pipe ⊒ Snuff		
19. Physical Measurements	Height	Current Weight	Weight 1 Yea Ago	Reas	on for Weight C	Sain or Loss			
Fill in information for the Proposed Primary Insured.									
20. Personal Physicians	N. CD	151	Proposed Pr Insured		d Additional sured	Any (	Child		
If Child Rider coverage is	Name of Pers Address:	sonal Physician:							
requested, use Special Instructions	Telephone N	umber.							
Section to add Personal Physician	Date last con								
information for each	Reason last of	consulted:							
child.	Treatment given medication property								



21. Personal Details	All questions are to be answered by each Proposed Insured. For each yes answer, indicate the appropriate item(s) and provide details.				Prin	Primary Ad			roposed dditional nsured Any Child	
Explain all "yes"	yes answer	, indicate the appropr	riate iterri(3) ai	ia provide details.	Yes		Yes		Yes	No
answers in Section 22 Details box below unless instructed otherwise.	applicati	u ever had any applica ion for reinstatement fo ed, rated-up or limited?	r Life or Health	Health Insurance <i>(or any Insurance)</i> declined,		×				
instructed otherwise.	b. Have you ever applied for or received disability payments for any illness or injury?					×				
	c. In the past 3 years have you engaged in, or do you in flying as a pilot, student pilot, or crew member; organi automobile, motorcycle, or any type of motor-powered diving, mountain climbing, hang gliding, parachuting, jumping, soaring, or ballooning? (If "yes", complete a Hazardous Activities Questionnaire.)									
	d. Have you been cor	u ever had your driver's nvicted of driving while en convicted of more the		×						
	e. Except a	i ever used, or been any other narcotic or		×						
	f. Have you ever been charged with a violation of any criminal law?					×				
	g. In the next 12 months, do you plan to travel or reside outside of the United States or Canada? (If "yes", complete Supplement for Foreign Nationals or Travel.)									
		pelong to or intend to joution? (If "yes", comple		r reserve military or naval us Questionnaire.)		×				
	<ul> <li>i. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?</li> <li>j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If "yes", provide relationship to Proposed Insured(s), age at death, and cause of death, and if cancer, provide type.)</li> </ul>					×				
						×				
22. Explanation of Personal	Question Letter	Person	Dates		De	tails				
Details If more space is needed, an additional										
blank sheet may be attached. Any										
Proposed Insured(s) or Owner(s) should sign and date										
additional pages.										

#### **HEALTH INFORMATION** Proposed Proposed 23. Health To the best of your knowledge and belief, has anyone here proposed Any Primary Additional Questions for insurance ever consulted a licensed health care provider for, been Child Insured Insured treated for, taken medication for, or been diagnosed as having: All questions are to Yes No Yes No Yes No be answered by a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-× each Proposed related condition, or received a positive result of an HIV (Human Insured. Immunodeficiency Virus) test? Explain all "yes" Heart disease including heart attack, angina, or other chest pain, × П answers in Section cardiomyopathy, shortness of breath, congestive heart failure, heart 24 Details box murmur, or other disorder of the heart? unless instructed c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, × otherwise. or high triglycerides? Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, × peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism? × e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, П Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder? f. Depression, neurosis, affective disorder, psychosis, or any other mental × or emotional disorder? Asthma, emphysema, chronic bronchitis, tuberculosis, or any other × disease of the lungs or respiratory system? × h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract? Sugar, protein or blood in the urine, kidney stones, sexually transmitted × disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system? Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, × or thyroid? Disorder of the blood including anemia, sickle cell disorders, × thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors? Cancer, or any malignant or benign tumor or cyst, or any chronic × disease of the skin or lymph glands? m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic × back or muscle condition? n. Alcoholism, narcotic addiction, drug use, or hallucinations? × П × o. Any disease or disorder of the eyes, ears, nose or throat? П П To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance: p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.) q. Had any disease, disorder, injury, or operation not already disclosed on П × this application? r. Had any x-rays, electrocardiograms, or other medical tests for reasons × not already disclosed on this application? Been medically advised to have any surgery, hospitalization, treatment × or test that was not completed or results that you have not received? Currently taking any medication other than indicated above to include × prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.) Used alcoholic beverages? (If yes, how much, what kind (beer, wine, × liquor), and how often?)



	_		1	D.1.7.
24. Details of Health History	Question Letter	Person	Dates	Details (Be specific. Give full names, addresses and telephone numbers (if available) of physicians, hospitals, etc.)
If more space is needed, an additional				(ii available) oi priysiciaris, riospitais, etc.)
blank sheet may be				
attached. Any Proposed Insured(s)				
or Öwner(s) shouÌd				
sign and date additional pages.				
	<i>If</i> 112 212 212 2			and the short Ann Dran and Income (short of Come (short of Sings and date
25. Special Instructions Section	If more space additional pag		al biank sheet m	ay be attached. Any Proposed Insured(s) or Owner(s) should sign and date
PART C – FRAUD ST				
WYOMING only:	defraud or ki	nowing that he/she is	facilitating a fra	n containing a false or deceptive statement, and does so with intent to ud against an insurer, may be guilty of insurance fraud.
ARKANSAS and RHODE ISLAND	Any person	who knowingly prese ation in an application	nts a false or fr n for insurance	audulent claim for payment of a loss or benefit or knowingly presents is guilty of a crime and may be subject to fines and confinement in
only:	prison.			
COLORADO only:	FACTS OR ATTEMPTIN INSURANCI WHO KNO' POLICYHOI POLICYHOI PROCEEDS OF REGULA	INFORMATION TO IG TO DEFRAUD TH E AND CIVIL DAMAO WINGLY PROVIDES LDER OR CLAIMAN LDER OR CLAIMAN S SHALL BE REPOR ATORY AGENCIES.	O AN INSURA IE COMPANY. GES. ANY INS F FALSE, INC T FOR THE PU T WITH REGAR TED TO THE C	KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING ANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF GURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY OMPLETE OR MISLEADING FACTS OR INFORMATION TO A JRPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE RD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE OLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT
Pre-Notice of	This notice insurance:	is to inform you that	as part of our i	normal underwriting procedures in connection with an application for
Procedures as Required by	<ul> <li>An invest</li> </ul>	igative consumer rep	ort may be ma	de whereby information is obtained through personal interviews with
The Fair Credit	your neig general r	hbors, friends or othe eputation personal c	rs with whom yo haracteristics a	ou are acquainted. This inquiry will include information as to character, and mode of living, except as may be related directly or indirectly to
Reporting Act	your sexu	uál orientation, with r	espect to you,	members of your family, and others having an interest in or closely
of 1970	<ul> <li>You may</li> </ul>	d with the insurance to elect to be interviewe	ed if an investig	ative consumer report is prepared in connection with this application.
	You are e	entitled to receive a co	py of any inves	tigative consumer report by submitting your request in writing.  sonable time after you receive this notice, additional information as to
	the nature for additi Columbus	e and scope of the in onal information add s, Ohio 43218-2835l.	vestigation, if or Iressed to Nati In the event of	ne is made, will be provided. You may send corrections and requests conwide Life and Annuity Insurance Company, [P.O. Box 182835, an adverse decision, you will be notified in writing.
Medical	Information i	egarding your insural	oility will be trea	ted as confidential. Nationwide Life and Annuity Insurance Company, ef report thereon to the Medical Information Bureau, a non-profit
Information Bureau Disclosure Notice	membership	organization of life	insurance com	npanies, which operates an information exchange on behalf of its
DISCIOSUIE NUUCE				mber company for life or health insurance coverage or a claim for reau, upon request, will supply such company with the information in
	its file. Upo	n receipt of a request	t from you, the	Bureau will arrange disclosure of any information it may have in your
	in accordance	ce with the procedure	es set forth in t	n the Bureau's file, you may contact the Bureau and seek a correction he Federal Fair Credit Reporting Act. The address of the Bureau's
	information (	office is [50 Braintree	Hill, Suite 400	, Braintree, Massachusetts 02184-8734, telephone number 866-692- of the Bureau's information office is www.mib.com. Nationwide Life
	and Annuity	Insurance Company	or its reinsure	er(s) may also release information in its file to other life insurance lth insurance, or to whom a claim for benefits may be submitted.

PART D – AGREEME	<u>INT, AUTHORIZATIO</u>	N AND SIGNATURE					
Agreement	I understand and agree that:						
	• This application, any amendments to it, and any related medical examination(s) will become a part of the Policy are the basis of any insurance issued upon this application.						
	<ul> <li>The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer of</li> </ul>						
	Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or						
	make or change any contract; or waive or change any of the Company's rights or requirements.  • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to						
	the extent set for	th in that Agreement.					
	• If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is						
	issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge						
	and belief when (1) and (2) have occurred.						
Authorization	I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit						
	managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization,						
	institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health						
	record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life						
	Insurance and to in	ruicai, foi the purpose of underwhiling Ivestigate claims . By my signature be	low, I acknowledge that any agreements I have made to				
	restrict my protected	I health information do not apply to this	form; and I instruct any physician; health care professional;				
	hospital; clinic; phar	macy or pharmacy benefit managers; medical/backth record without restriction	nedical facility, or other health care provider to release and				
	pursuant to this fo	medical/flealitt record without restriction may be redisclosed and no long	on. I understand that any information that is disclosed ger be covered by federal rules governing privacy and				
	confidentiality of hea	alth information. This form, or a copy of	f it, will be valid for a period of not more than two years (24				
	months) from the da	ate it was signed. I understand that I h	ave the right to revoke this form in writing, at any time, by and Annuity Insurance Company, [Attention: Underwriting,				
	P.O. Box 182835, C	columbus, Ohio 43218-2835]. I underst	and that a revocation is not effective to the extent that any				
	of my providers have relied on this form; or to the extent that Nationwide Life and Annuity Insurance Company has a						
	legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete records, or, if I revoke this authorization before a policy is issued, Nationwide						
	Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized						
	representative or I have a right to a copy of this form by sending a request to Nationwide in writing.  I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE						
Proposed		S APPLICATION AND AGREEMENT AN VLEDGE AND BELIEF. I UNDERSTAN					
Insured(s) and Owner/Trustee	DEST OF WIT KINON	VEEDOL AND BELIEF. FONDERSTAN	D AND ACITE TO ALL ITS TERMS.				
Signatures	Circulate Ann City Ann City						
STOP	Signed at	Any City, Any State City/State	on July 28 , 2008 Month/Day Year				
		City/State	Month Day Teal				
All Financial questions in Section		John D. Doe	X				
16 (a through f) are	Full Name o	f Proposed Primary Insured (print)	Signature of Proposed Primary Insured				
required to be			(or parent if Proposed Primary Insured is under age 15)				
answered for both			Χ				
the Proposed	Full Name of	Proposed Additional Insured (print)	Signature of Proposed Additional Insured				
Insured(s) and		1	(if to be Insured)				
Owner, if not Proposed	.,		V				
Insured(s).	XSign	nature of Applicant/Owner	XSignature of Applicant/Owner				
msurcu(s).		than the Proposed Insured(s))	(if other than the Proposed Insured(s))				
PART E - PRODUCEI	· · · · · · · · · · · · · · · · · · ·	and the Proposed medicale)	(in other than the riversed insured(s))				
Producer's	¥ Yes □ No	a. I have truly and accurately recorde	ed all Proposed Insureds' answers on this application.				
Certification	¥ Yes □ No		ature(s) hereon. (If "no", provide details in Special				
STOP		Instructions Section.)					
Be sure to answer	☐ Will <b>区</b> Will Not		insurance applied for will or will not replace any Life				
all three questions.		Insurance, and/or Annuities.					
, , , , , , , , , , , , , , , , , , , ,							
	Sam A. F	Producer	X X Sam A. Producer				
	_	Producer's Name (print)	Signature of Producer				
			. 9				
	Any Firm		02-A000000				
		Firm	Producer's Nationwide #				



## TEMPORARY INSURANCE AGREEMENT

This Agreement provid				rage, for a limited period of time, subject to the terms of this Agreement.		
HEALTH QUESTION						
STOP	Proposed Primary Insured	Proposed Additional Insured	Any Child	Has anyone here proposed for insurance:		
Question must be	Yes No	Yes No	Yes No	To the best of your knowledge and belief, within the past 10 years, been		
answered by each Proposed Insured(s).				treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?		
	no represen temporary ir	r question is an Itative of Nation Isurance receip	nwide Life and	or LEFT BLANK, NO COVERAGE will take effect under this Agreement and Annuity Insurance Company is authorized to accept money, and/or provide a rant.		
TERMS AND CONDIT						
Amount of Coverage [\$1,000,000] overall maximum for all	mode select payment for Nationwide	ted has been pan application will pay to the d	paid and acce for Life Insura esignated Bei	ent will commence on the date of the application if the full first premium for the epted by Nationwide or authorized by Electronic Funds Transfer as advance ance. If any Proposed Insured dies while this temporary insurance is in effect, neficiary the lesser of:		
applications or agreements.	<ul> <li>the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or</li> <li>[\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.</li> </ul>					
Date Coverage	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:					
Terminates	<ul> <li>the date a</li> </ul>	<ul> <li>60 days from the date of this signed Agreement, or</li> <li>the date any policy is offered or issued to the Proposed Insured in connection with the above application, or</li> </ul>				
60 DAYS maximum coverage.	<ul><li>the date</li></ul>	<ul> <li>the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed</li> </ul>				
Limitations	<ul> <li>Insured, or the Owner, if different than the Proposed Insured.</li> <li>Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made.</li> <li>This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement.</li> <li>If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made.</li> <li>There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank.</li> <li>No one is authorized to waive or modify any of the provisions of this Agreement.</li> </ul>					
SIGNATURES						
Proposed Insured(s) and Owner Signatures	TRUE TO T	HE BEST OF N	1Y KNOWLED	AVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE DOCE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.		
owner organical	Dated (mm/	<i>'dd/yyyy</i> ) <u>Jul</u> y	28, 2008	X John D. Doe Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15)		
	X	Signature o	of Applicant/On e Proposed In			
Initial Premium Receipt and Producer's Signature	An initial pre advised the	emium payment Applicant/Own	in the amoun er that addition	t of \$ has been submitted with this application. I have nal premium may need to be submitted at time of delivery.		
Be sure to include the amount of the initial premium payment.	XS	Sam A. Produce Signature	er of Producer	Any Firm 02-A000000 Firm Producer's Nationwide #		



Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE REVISION

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: LAA-0111M1, Application for Individual Life Insurance REVISION

Project Name/Number: LAA-0111M1, Application for Individual Life Insurance REVISION/LAA-0111M1, Application for Individual Life Insurance

REVISION

## **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification

Comments: Attachment:

AR CERT NWLA.pdf

Item Status: Status

Date:

Satisfied - Item: Application

**Comments:** 

This is an application filing. All forms to be used with the applications are listed with approval dates in the general description.

Item Status: Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability-M1.pdf



Form Numbers:

#### **ARKANSAS**

### Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

LAA-0111M1, Application for Life Insurance LAA-0112M1, Application for Life Insurance LAA-0113M1, Application for Life Insurance

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief, they are in compliance with the rules and requirements of Regulation 19 and 49 of the Arkansas Statute, ACA 23-80-206, ACA 23-79-138, and Bulletin 11-88.

These forms meet the Flesch readability requirements as explained in Title 23-80-206 of the Arkansas Insurance Code.

James J. Rabenstine Vice President NF Compliance

Date: 08-25-2011

# NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY (07/2011)

## STATEMENT OF VARIABILITY FOR FORMS:

LAA-0111M1, Application for Life Insurance LAA-0112M1, Application for Life Insurance LAA-0113M1, Application for Life Insurance

Bracketed items in the above captioned forms indicate variability as follows:

## Page 3, Plan Information Section

Life Insurance Plan Names	The Plan Names are bracketed as they can change over time. We will remove or add Plan Names as appropriate.
Optional Benefits (Riders)	The Optional Benefits (Riders) are bracketed to allow us to add options as they are approved and to remove options that are discontinued. All the rider information for the previously approved riders will not change unless the rider is re-filed.

### Page 8, Part C - Fraud Statements and Important Notices Section

Pre-Notice of Procedures as	The address and/or telephone information is bracketed in case either change in the
Required by The Fair Credit	future.
Reporting Act of 1970	
and	
Medical Information	
Bureau Disclosure Notice	

### Page 10, Temporary Insurance Agreement, Terms and Conditions Section

Amount of Coverage	The current total benefit limit is bracketed in case it changes in the future.
--------------------	--